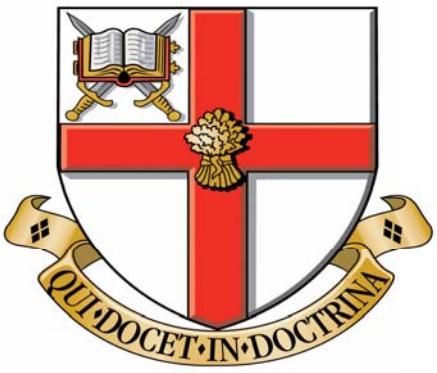

University of Chester

PATIENTS' PERCEPTIONS OF COMPLEMENTARY THERAPIES IN PALLIATIVE CARE

Donna M. Owen

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Abstract

The use of complementary therapies within palliative care is increasing, and many different therapies are now offered within the hospice setting. Much of the available literature concentrates on providing a scientific link between administered therapies and the benefit they give, palliative care is unique in that a cure is not sought; the aim of palliative care is to ensure maximum comfort and happiness for the patient and so if patients feel benefit from using a complementary therapy, one can argue that it should be available to them.

The work presented in this dissertation is a study of a particular group of palliative-care patients, and their experience of two types of complementary therapies - acupuncture and aromatherapy – as a model to indicate their value in other treatment contexts. The aim of the study is to examine palliative-care patients' perceptions of their experience of acupuncture and aromatherapy. A phenomenological approach is followed in this study utilising triangulation of methods. Six patients were approached and recruited, three of whom were commencing a course of acupuncture, and three of whom were commencing a course of aromatherapy. Prior to starting their chosen therapy, each participant completed the European Organisation for Research and Treatment of Cancer (EORTC) quality-of-life questionnaire. Throughout the therapy participants kept a daily diary describing how they felt each day. Upon completion of the course of therapy, participants were interviewed using semi-structured interviews

Four themes were identified from the interview transcripts and daily diaries: participants felt the therapy helped with pain, helped with relaxation, gave them 'me time', and they valued the counselling role of the therapist. Results were limited to four participants as two of the original six recruited were not eventually able to be interviewed. Palliative-care patients appear to find acupuncture and aromatherapy beneficial. All were glad to have had the therapy and wanted to have further similar therapy in the future. A qualitative approach proved very useful in gaining patients' perceptions. Two of the themes identified in this study are not apparent in previous literature and so further qualitative research would be informative.

Declaration

This work is original and has not been submitted previously in support of any qualification or course.

Authors Signature .....

Date .....

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Table of Contents

1. INTRODUCTION

1.1 Palliative Care and Complementary Therapies

Complementary therapies have been widely studied in recent years, at least in part due to an increase in their use by patients, whether inside or outside of their conventional practitioner's advice (Bandolier, 2007). The prevailing public attitude is that treatment services should be more patient-centred, and take into account the views of those patients and their families; this is reflected in UK Government policy (Department of Health, 1995).

Complementary therapies may be defined as therapies which are outside those of conventional medicine; however a formal definition of complementary medicine is elusive, and many therapies fall outside the conventional scientific method and the demands of evidence-based medicine. However, patients often access them alongside conventional treatments such as radiotherapy, or on their own once conventional treatments have failed (Tavares, 2003; Kellehear, 2003). The term 'complementary' implies that such therapies are used in conjunction with conventional treatment. The use of complementary therapies is rising in popularity and they are increasingly being used to enhance quality of life, (Wilkinson, Aldridge, Salmon, Cain & Wilson,1999; Schofield, Smith, Aveyard & Black, 2007) a reflection perhaps of their origin for example in traditional herbal remedies. Approximately one in four people use some form of complementary medicine and one in three people with cancer will access complementary medicine to help them manage symptoms of the disease (Hemming & Maher, 2005).

Palliative care describes the holistic care of patients with advanced disease, and includes management of pain and other physical symptoms, as well as psychological, social and spiritual wellbeing (World Health Organisation, 1990; National Council for Hospice and Specialist Palliative Care Services, 2002). The aim of palliative care is not to cure the patient, but to improve their quality of life before death. In some cases it is not possible for conventional medical treatments to control symptoms during palliative care – for example the control of pain - and such cases are when other options could be considered. In palliative care, patients are viewed as an integrated whole rather than 'fragments' (for instance, a particular organ) which can be dissected and corrected as is typical in conventional medicine (Shenton, 1996). Since the aim of palliative care is to enhance quality of life, it is therefore not surprising that complementary therapies are increasingly being used by these patients within the conventional medical context; of course, some complementary therapies (such as acupuncture) have been used for many years, and pre-date modern medicine. Complementary therapies are seen to offer a more holistic perspective which fits with the ethos of palliative care (Schofield et al., 2007).

Services for palliative-care patients have received greater government attention in recent years (Department of Health, 1995); these government documents highlight the importance of listening to what the patient wants (DH, 2000; DH, 2006), and to plan services around their views. Although research into dying is sensitive, the patient's voice cannot be forgotten (Mak, Elwyn & Finlay, 2003) and obtaining their views is the best way to gauge benefit (Corner & Clark, 2002). Arguably, in palliative care the only way is to gain patients' views, since almost no-one planning services can know

how it feels to have a terminal illness and therefore, what the needs of the palliative patients are. A study is therefore useful in this context in helping to establish what palliative-care patients see as an effect from the complementary therapies they may have received. It is also more cost-effective to know how well a treatment works before making the decision to fund it. Funders of palliative care services need research to inform them whether or not to provide complementary therapies (Westcombe et al., 2003). It will also help to inform hospices who currently offer these services. This research will contribute to this knowledge base.

1.2 Acupuncture and Aromatherapy

This study will be concerned with acupuncture and aromatherapy, and it is therefore helpful to define what is meant by these terms. Acupuncture involves the insertion of fine needles into specific points in the body (Tai, 2002). It is thought to work by restoring the flow of 'chi' - or energy - by stimulating specific points of the body (Linde et al., 2001). It is based on the principles of traditional Chinese medicine. 'Chi' is thought to circulate between organs along channels, and must flow in the correct 'strength' and 'quality' to maintain health. Acupuncture provides a means of 'altering the flow of chi' if it is wrong (NHS Centre for Research and Dissemination, 2001) to restore well-being.

Aromatherapy massage combines the use of touch with essential oils. Massage, particularly aromatherapy massage, is one of the most popular complementary therapies (MacDonald, 2007); it is thought to improve circulation, relax muscular and nervous tissue, and speed up elimination of waste products (Gray, 2000). Essential

oils are lipid-soluble and so are rapidly absorbed through the skin and transported around the body (Evans, 1995; Price & Price, 2007). The oils are thought to travel through the blood to the part of the body where they are most needed, for example the site of pain. Relevant research to date about aromatherapy and acupuncture is explored in the literature review.

1.3 Aims and Objectives

The purpose of this research is to explore perceptions of acupuncture and aromatherapy experienced by palliative-care patients attending a day hospice. A group of patients is studied through their keeping of symptom diaries and by conducting interviews after a treatment period. The analysis of this data is used to indicate the effect of these complementary therapies upon the patients' quality of life. Later sections of this dissertation discuss the methodologies, patient selection, and analysis used.

2. LITERATURE REVIEW

The Current Index to Nursing and Allied Health Literature [CINAHL] (1982-date), Blackwell Synergy (1998-date), the British Nursing Index (1994-date) and the Cochrane Collection databases were searched for papers relating to aromatherapy, acupuncture and complementary therapies in palliative care. Articles were also retrieved from the 'Complementary Therapies in Nursing and Midwifery' online journal archive (2000-2004). Search terms included 'complementary therapy', 'acupuncture', 'aromatherapy', 'palliative care', 'systematic review' and combinations of these to identify relevant research to date. Studies conducted prior to the recent changes in the provision of cancer services (DH, 1995) were eliminated to ensure only up-to-date research was identified. Studies prior to this may not be as relevant as there have been changes in the way services are offered to these patients. Whilst palliative care is not confined to those with a cancer diagnosis it is cancer patients that have been recruited in the present study.

There are few studies which examine the general use of complementary therapies but it is useful to review these to gain an understanding of them. Following this, studies specific to aromatherapy and acupuncture are also reviewed. Studies have been included which are specific to cancer as well as to palliative care because it is widely documented that almost one in four people die from that disease (DH, 2007).

Downer et al. (1994) examined the number of patients within two hospitals in inner London - St Bartholomew's and Homerton Hospitals - who were receiving some form of complementary therapy (relaxation, healing, homeopathy, herbalism,

visualisation and diets) and their satisfaction with the outcome of using the therapy. Data was collected using a postal screening questionnaire followed by semi-structured interviews (interviews with set questions allowing the interviewer to guide the topic covered but allowing for open responses); all those who had used any form of complementary therapy were invited to participate. Four hundred and fifteen patients returned the postal questionnaire (69%) and forty-eight patients agreed to take part in the interview. It was concluded that a number of cancer patients opted to use a complementary therapy (16% of those who were contacted and returned the questionnaire) and that satisfaction was high (82% were satisfied or very satisfied). Those who felt the therapy had helped them reported psychological benefits such as hope and optimism; patients reported feeling calmer after practising relaxation techniques. This study used both quantitative and qualitative methods. The postal questionnaires were used to quantify how many cancer patients attending the two hospitals used a complementary therapy, and to identify specific characteristics such as age, gender and social class.

Garnett (2003) examined why complementary therapies are used in cancer care. A sample of palliative-care nurses were recruited, by writing to nurse managers from a selected section of the 1996 Directory of Hospices and Palliative Care Services. Eighteen participants were recruited and interviewed. Whilst this study involves interviews with therapists rather than patients themselves receiving a therapy, it does give an insight into why patients opt to use complementary therapies and why it is important to provide those therapies to palliative-care patients. The themes that arose

from these interviews were that complementary therapies help people feel looked after, less anxious, and empowered.

Oneschuk, Hanson & Bruera (2000) conducted a study to ascertain why people with advanced cancer use complementary therapies and what beneficial effects these therapies have. To do this a six-question survey was administered to 154 advanced-cancer patients; however, only sixteen patients actually completed the survey. Some were excluded due to ill health; others refused to take part. Thirteen of the sixteen patients indicated a subjective beneficial effect. This study highlights the difficulties with recruitment and retention of participants in palliative-care research. Due to the method of investigation that was chosen, not enough patients participated to make this a reliable study; it does, however, draw attention to the need for further investigation. Being quantitative, this study could not capture the feelings of the participants in the way that a qualitative study could have: quantitative surveys aim to measure attitudes, knowledge and behaviour, not to unravel feelings (Bowling, 2002). Sixteen participants is not sufficient for survey research: such small samples in quantitative research are unlikely to yield results of significance (Parahoo, 1997).

One study which does examine the feelings of the participants through use of semi-structured interviews was conducted by Humpel and Jones (2006). The study was conducted to gain an insight into what complementary therapies patients use, why they use them, and what benefit they gain from using them. Participants were recruited by placing posters and flyers in medical waiting rooms at various cancer treatment centres. Nineteen patients took part, ten with breast cancer, four with prostate cancer, three with cancer of the colon, one with lung cancer, and one with

cancer of the liver. Ten were still undergoing conventional treatment and nine had completed their treatment. Overall themes which emerged, as to why patients opt to use complementary therapies, were 'doing as much as possible to help themselves' and 'boosting the immune system through use of herbal supplements'. Overall, participants reported feeling happy with the outcome of their chosen therapies, which included meditation, homeopathy, Pilates and ingestion of vitamins and minerals. This study is useful because it attempts to identify the feelings of the participants. The sample size was sufficient for a qualitative study and this enhances the validity and reliability of the findings. However, all the participants were either undergoing treatment or had just completed treatment. None of them were palliative-care patients and so their feelings could differ considerably from participants who are receiving palliative care. A palliative-care patient has to come to terms with the fact they are dying, whereas a patient undergoing curative treatment has hope of a cure. A palliative patient may well opt to use a complementary therapy for very different reasons than a patient who may be cured from their disease. Whilst similarities can exist, it would be wrong to assume their feelings are the same.

Studies such as the ones given above draw our attention to the popularity of complementary therapies and the need for further research into their benefits. Of the research examined on complementary therapies in general, the results appear promising: all the studies mentioned above indicate a subjective beneficial effect. It is now necessary to examine more closely the two therapies under investigation here: aromatherapy, and acupuncture.

2.1 Aromatherapy

There are limited studies which examine aromatherapy as specifically used in palliative care and so some of the studies included here look at symptom relief in cancer care and do not specify that participants are palliative. However, these were included because palliative care has a role throughout the cancer journey (Addington-Hall, 2002). Fellowes, Barnes and Wilkinson (2004), conducted a systematic review of the research to date on aromatherapy and symptom relief in cancer. All of the studies reviewed (ten in total) demonstrated some benefit from aromatherapy. An improvement was reported in anxiety by Ahles et al. (1999) and Corner, Cawley and Hildebrand (1995). Wilkie et al. (2000) found a reduction in reported pain after the first and third massage, but not after the second and fourth. Reasons for this remain unknown, suggesting further research is required into the effects of aromatherapy on pain in palliative care. Overall there is insufficient evidence to draw conclusions about the benefits of aromatherapy massage for cancer patients (Fellowes, Barnes & Wilkinson, 2004).

2.2 Quantitative approaches in aromatherapy

A number of authors have attempted to look at the benefits of aromatherapy using a quantitative method. The benefit of aromatherapy for patients attending a palliative care day centre was studied by Wilcock et al. (2004). In a randomised controlled pilot study, forty-six patients were recruited and allocated to the treatment group, receiving aromatherapy, or control group. A large number of patients withdrew and only twenty-nine patients completed the study. Using a numerical rating scale,

results showed no statistically significant difference in mood, quality of life or physical symptoms between groups. In other words participants did not report any improvement. This study suffered a high patient withdrawal rate over the four week period it was conducted. This can be explained partly due to the deteriorating condition of patients who become unable to continue. Despite the results, all patients chose to continue with aromatherapy after completing the study citing 'feeling relaxed' and 'invigorated' as the reasons.

There is anecdotal evidence to suggest aromatherapy may have beneficial effects on physical and psychological symptoms in advanced cancer (Soden, Vincent, Craske, Lucas & Ashley, 2004). Whilst there is evidence that aromatherapy may be helpful for anxiety reduction in the short term, few studies have looked at the longer term effects. Soden et al. (2004) attempted to do this by use of a randomised control trial. Patients were randomly allocated into three groups; one group received a weekly massage with an aromatherapy oil, one group received a massage with an inert carrier oil and the third group received no massage at all; no other interventions were specified in the paper. They were all asked to complete weekly self-assessments of pain, sleep and anxiety. Results showed a statistically-significant reduction in pain in the aromatherapy and massage group. Patients in the aromatherapy group tended to sleep better post-massage and scored better on the anxiety scale after the second and fourth treatment. This benefit may be due to the increased time spent with the participants rather than due to the aromatherapy itself. Whilst this study gives us some knowledge of the benefits of aromatherapy it does not unravel participants' feelings.

Wilkinson et al. (1999) studied the effects of aromatherapy and massage using semi-structured questionnaires. They also utilised two anxiety scales and a symptom check list. Patients were recruited via the aromatherapy co-ordinator at a palliative-care centre. One hundred and three patients were recruited, allocated into the aromatherapy group or massage group, and given a questionnaire two weeks post-massage. Anxiety scales were completed before and after each massage and one week after the last massage. One group received a full-body massage with carrier oil only and the other group received a full-body massage with carrier oil and an aromatherapy essential oil. Both groups showed a reduction in anxiety after each massage suggesting that it is the act of massage rather than the aromatherapy that reduces anxiety. Eighty-seven patients completed the study and there was found to be a statistically-significant reduction in anxiety after each massage. Patients were asked about any pre-test symptoms and then again post-test. For example 91% of respondents felt they suffered from anxiety pre-test; post-test this had decreased to 85%. However, participants were asked to complete an anxiety inventory questionnaire directly after each massage when, arguably, they are likely to be feeling relaxed and therefore rate it as a positive experience. The results suggest that massage is beneficial in reducing anxiety but they do not provide information regarding how long this benefit is maintained for. It is therefore necessary that further research is conducted over a longer period of time. This is also a quantitative study and so whilst it enables a large sample size, it cannot examine the feelings of the participants.

Westcombe et al. (2003) conducted a randomised control trial to examine the effectiveness of aromatherapy in improving psychological distress and quality of life

in patients with advanced cancer. One problem encountered was in the recruitment of patients: some were too ill to take part whilst others declined. Some were not informed of the study because the referrer felt they should not be approached. Results were not published in this paper, just the problems encountered. The experience of Westcombe et al. (2003) suggests that it is difficult to recruit a large sample in palliative care and so smaller-scale studies may be more appropriate.

A very recent study conducted by Wilkinson et al. (2007) examined the effectiveness of aromatherapy in the management of anxiety and depression in cancer patients. Two hundred and eighty eight patients participated and were recruited at the point they were referred for therapy. All were specifically referred for aromatherapy to treat anxiety or depression. Using anxiety questionnaires, participants reported an improvement in anxiety mainly after weeks six and ten of therapy. The authors concluded that aromatherapy massage does not appear to benefit patients with anxiety or depression in the long term but may have a short-term effect. This study has many merits and should be considered significant in this field. It has a large sample size and so the results are more likely to be valid and reliable. Also it concentrated solely on anxiety and depression instead of all symptoms. What it cannot provide is an insight into the participants feelings in an in-depth qualitative way and it is not clear whether the benefit is cumulative or specific to weeks six and ten.

Evans (1995) conducted an audit into the effects of aromatherapy in palliative care: almost all of the participants (80%) reported a benefit in some way. Participants were asked how they felt before the massage and how they felt after the massage. Although this was only an audit, it provides information that suggests a beneficial link

between massage and a reduction in pain, anxiety and nausea. However, most patients were only seen once and so no conclusions can be drawn as to how long any benefit is felt for, and whether a full course of therapy provides more benefit than a one-off massage. Participants were simply asked if they felt 'better, worse or the same'. They therefore did not get to discuss their feelings to unravel the real felt benefits.

Of the quantitative studies examined, two indicated no beneficial effect whereas four found a statistically-significant beneficial effect.

2.3 Aromatherapy and qualitative approaches

Upon reviewing the literature it became clear that quantitative rather than qualitative approaches predominate. One qualitative study was identified in particular: Dunwoody, Smyth & Davidson. (2002) studied patients' views of aromatherapy using a focus group. Participants had all received six one-hour sessions of therapy prior to the focus-group meeting; ten females and one male agreed to take part. Participants discussed the de-stressing effects of aromatherapy and how they valued the counselling role of the therapist. The study provides data to suggest that patients find aromatherapy beneficial but the sample size was small. The use of focus groups as a method of study can be criticised: depending on the participants involved, the data may be largely from one or two outspoken members of the group and therefore not representative of the whole group. This cannot be ascertained from the research findings. Also, confidentiality cannot be maintained in a focus group setting and this may inhibit participants from saying how they feel. Finally, focus groups should

ideally be balanced in relation to the age, sex and ethnicity of respondents (Bowling, 2002). In this case there were ten female participants and one male.

Having reviewed the available literature regarding the benefits of aromatherapy massage in palliative care, one can conclude that whilst a benefit is likely more evidence is required (Bandolier, 2007). It has been difficult to find evidence regarding patients' perceptions: most studies focus on the actual measurable benefits of therapy and not the views of the patient. Whilst there is a clear need for quantitative studies which aim to establish whether there is any benefit to using a complementary therapy in symptom control, the patients feelings and views are equally important.

From the literature above it would appear that aromatherapy is beneficial to palliative-care patients. Five studies reported a reduction in anxiety in their results (Ahles et al., 1999; Dunwoody, Smyth & Davidson, 2002; Wilkinson et al., 1999; Wilkinson et al., 2007. & Evans, 2005.). Three studies reported a reduction in pain (Wilkie et al., 2000; Soden et al., 2004 & Evans, 2005). No studies oppose these finding but Wilcock et al. (2004) did state that they could find no statistically-significant difference in mood, quality of life or physical symptoms between the treatment group and the control group. However, even these authors reported positive findings such as participants feeling relaxed and invigorated.

2.4 Acupuncture

There is little literature available on acupuncture in palliative care and a lack of high-quality evidence to support its use (Filshie, 2005). Acupuncture remains a controversial subject partly due to concerns over its safety (Ernst, 2005) and is thus

viewed differently to aromatherapy; studies such as the present thesis can help its assessment. Due to the lack of research specific to palliative care, studies of acupuncture treatment of general symptoms, which may also be relevant for palliative-care patients, will now be discussed.

Vickers (1996) examined acupuncture for the treatment of nausea and vomiting and concluded that real acupuncture is more effective than sham acupuncture; patients were recruited who had a variety of conditions, including morning sickness, motion sickness, and post-operative distress. A number of controlled trials have also been conducted to explore the benefits of acupuncture for anxiety and depression. Allen, Schnyer and Hitt (1998) studied thirty-eight women with severe depression over an eight-week period of treatment. They concluded that the treatment group were not significantly improved than the non-treatment group. However, the participants were all women with severe depression. Anxiety associated with a palliative illness may be different to severe depression and so results from trials such as this cannot be assumed to apply; in palliative care, anxiety is often related to the fear of death and dying (Payne, Seymour & Ingleton, 2004). The NHS Centre for Reviews and Dissemination [CRD] (2001) reported that acupuncture in palliative care has not been specifically examined: studies have, however, investigated the benefit of acupuncture in acute and chronic pain, asthma, nausea and vomiting, obesity, tinnitus and addiction. Whilst acute pain and nausea and vomiting are common symptoms among palliative patients, their needs are specialised. Randomised control trials have been of varying quality and provide conflicting evidence (CRD, 2001) and so the validity of these trials is questionable; current evidence is therefore insufficient to guide practice.

Vickers, Feinstein, Deng & Cassileth (2005) studied the effects of acupuncture on dyspnoea in advanced cancer: forty-seven patients with lung or breast cancer experiencing dyspnoea were recruited. All were randomly allocated to the treatment group, who received acupuncture, or the control group, who received a placebo. Results showed that acupuncture was unlikely to affect dyspnoea any more than a placebo. As this study was quantitative, whether the participants felt a general benefit from the acupuncture is not known.

One Cheshire hospice has gained positive results from providing acupuncture. In 1997 they treated forty-seven patients with acupuncture. Of these, fifty-five percent reported a worthwhile response in terms of pain relief (Leng, 1999). The paper suggests that acupuncture has a place in the treatment of bone and neuropathic pain. Although this is encouraging, it does not specify the method in which these results were gained and so should be used with caution.

Linde et al. (2001) conducted a systematic review of the available evidence of the benefit of acupuncture. Thirty-nine studies were reviewed and the results suggest that acupuncture is effective in post-operative nausea and vomiting and in treating post-operative pain, but it concluded that more research was needed. None of the studies reviewed by Linde et al. looked specifically at its use in palliative care. This may be due to the ethical issues that would be raised if a study involving palliative-care patients was to have a control group.

Ernst (2005) also conducted a similar general review of acupuncture. Of the thirty-eight studies they listed only two were specifically related to palliative care: Lee, Schmidt & Ernst (2004) examined acupuncture for the relief of cancer-related

pain. Results did not demonstrate effectiveness. Gadsby, Franks, Jarvis & Dewhurst (1997) looked at whether acupuncture-like electrical nerve stimulation improved quality of life for patients in a palliative care setting. Fifteen patients admitted for symptom control were allocated to receive standard treatment plus electrical nerve stimulation, or standard treatment plus a placebo treatment. The outcome was measured using the EORTC quality-of-life questionnaire. Symptoms of pain, nausea and vomiting were not improved but symptoms of fatigue showed some improvement; overall quality of life was improved. The authors acknowledge that it is difficult to draw conclusions based on a small sample. It would have been useful to have included a qualitative element to the study to enhance the validity and reliability of the results.

Available research on acupuncture in palliative care is predominantly quantitative. Of the studies reviewed here, two report no statistically significant benefit whereas two report a possible beneficial effect. This is not sufficient to guide practice. Small qualitative studies would be more appropriate for acupuncture, which aims to be holistic and patient-centred (Schofield et al 2007).

A review of the literature has indicated a need for the present study. There is a lack of qualitative studies relating to both aromatherapy and acupuncture in palliative care. Studies to date have given an insight into the use of these therapies in palliative care and themes such as relaxation, pain relief and reduction in anxiety are emerging.

3. RESEARCH METHODS AND DESIGN

3.1 Introduction

It was important from the outset to underpin this research with an appropriate scientific paradigm. Paradigms are sets of beliefs and practices which regulate inquiry within disciplines (Weaver & Olson, 2006). Health-care research commonly follows the positivist, naturalist, and critical theory paradigms. Positivism assumes there is a single objective reality which can be ascertained and tested; to evidence this, hypotheses are tested on a sample population with the aim of being able to generalise the findings to the larger population (Holloway & Wheeler, 2002). This approach, however, does not fit with the research question posed in this study. This study is not concerned with proving a hypothesis, or indeed generalising the findings to the wider population, but with providing information that is applicable to the population under investigation and which can be examined further. Critical theory assumes that an ideal truth exists: research is then a means for taking action, and determining a path to how things should be (Weaver & Olson, 2006); this method was also considered inappropriate for this research as the researcher holds no assumptions and does not believe an ideal truth exists. In contrast, the naturalistic approach is used to study the complexity of human interaction (Jack, 2006) through observation. This research study involves examining feelings as expressed by patients; there cannot be a correct way for a patient to feel – we must accept what they say. Naturalism is therefore a paradigm well-suited to this research and was therefore chosen to underpin this study.

Next it was necessary to examine which underlying philosophy/methodology fitted this study. All research is subject to underlying assumptions and it is important to be aware of this from the outset. All choices are governed by the research question and the aims of the study (Casey, 2006). The underlying philosophy considered most suitable for the present research was a phenomenological one. Phenomenology as a philosophy is attributed to Edmund Husserl (Rapport & Wainwright, 2006), who felt there was a need for a philosophy whereby assumptions are suspended and the world is seen through the eyes of the research participant. A phenomenon can only exist therefore when a subject experiences it (Sadala & Adorno, 2002): the researcher has to put aside any prior thoughts or judgements about the phenomena under investigation. This may sound relatively straightforward but in practice it can be difficult to achieve. In Husserlian phenomenology preconceptions are put aside or 'bracketed' so that the true phenomenon can be revealed (Paley, 1997). Heidegger argues that bracketing is impossible - we are always already in the world in association with others, not as observing beings but as beings inseparable from that which is observed (Rapport & Wainwright, 2006). These difficulties will be discussed in the data analysis section.

The basic principle of phenomenology is that the researcher should remain true to the facts and how they reveal themselves (Husserl, 1960). Phenomenologists believe the research setting should be natural and un-manipulated (Bowling, 2002). It is important that the researcher puts aside their own beliefs and presuppositions to see the experience for itself (Patton, 2002): hence, the researcher's own views about whether complementary therapies work or not must not be explicitly expressed or

inferred in any way to the participants. The researcher must forget their own views so that they do not inadvertently influence their interpretation of the transcripts.

In this study individuals were studied in their own homes. To obtain people's feelings it is important that they are in an environment in which they feel most comfortable. If this research had been conducted in a hospital environment it is less likely that respondents would have revealed their true feelings. Beech (1999) argues that the possible meaning of the data must be tested to its limits: this may be done through reflection and further questioning. To avoid a participant's answers being misreported, they should be reflected back, perhaps also by rephrasing the original question, so that the researcher can check their understanding. A participant's feelings should not be influenced by the research setting and the researcher should try not to influence the participant's responses; if this was to occur, the true feelings of the respondent would not be captured.

Having decided upon an appropriate paradigm and methodology it was then necessary to establish a suitable way of following them. A number of questions had to be asked. Firstly, what was the study attempting to find out? Second, what practical considerations were there? Third, how have other researchers looked at similar research? Finally, what method will give the most data for analysis? (Silverman, 2005)? There are three common approaches to research: quantitative, qualitative and triangulation. Quantitative research looks at cause and effect: data is collected in an attempt to establish the likelihood that a hypothesis is correct. Quantitative research tends to collect data that can be converted into numbers in an attempt to establish statistical significance (Parahoo, 1997). Research tools used in quantitative research

include questionnaires and surveys. Qualitative research, on the other hand, is used to explore people's beliefs, experiences and behaviour. It aims to study people in their natural surroundings and collect naturally-occurring data; information obtained tends to be much more detailed. Qualitative research usually uses a naturalistic approach which seeks to study phenomena in context-specific settings (Hoepfl, 1997). This results in different knowledge being gained than in quantitative research.

In answering the above questions it became clear that a quantitative approach would not provide the data required. To obtain patients' perceptions of their experience of complementary therapies the research would need to delve deeply in to their beliefs and feelings; however, to be practicable this research needed to be small-scale. Researcher time was limited and so a large-scale study (which would itself require detailed statistical analysis) was out of the question.

Other researchers have explored the use of complementary therapies in palliative care and a variety of methods have been used. Randomised Control Trials (RCTs) are popular because of the high reliability and validity gained. RCTs utilise large sample sizes: for example, Westcombe et al. (2003) aimed to recruit 508 participants in their study, which looked at the effectiveness of aromatherapy in improving psychological distress and quality of life. Research on such a large scale would have been impossible for this study. RCTs also aim to provide a correlation between cause and effect. This study does not aim to measure an *objective* benefit but aims to demonstrate whether the patients *perceive* a benefit or not. Some researchers have used questionnaires, which allows them to look at a large sample. However, it is difficult to establish patients' perceptions through the use of questionnaires: a one-

word answer to a question would not provide sophisticated data for analysis. Although some researchers claim to collect qualitative data through asking an open-ended question as part of their questionnaire, there is no opportunity to unravel the real meaning of each individual's response as is possible with an interview which gives a greater quantity of data for analysis. Verbal communication is the most effective means in which to convey the feelings, views, experiences and intentions unique to each individual (Parahoo, 1997). Thus, it was decided that to gain information-rich data, a qualitative method should be followed.

Triangulation involves combining the use of quantitative and qualitative methods, or multiple combinations of these; data is strengthened by providing evidence from more than one source (Williamson, 2005). Triangulation was used in this research to enhance the results. Three methods of data collection were chosen: a quantitative preliminary questionnaire (the EORTC quality of life questionnaire), semi-structured interviews, and patient diaries. However, as Thurmond (2001) points out, the use of triangulation does not strengthen a flawed study but should be used if it can contribute to understanding the phenomenon.

3.2 Interviewing

Interviewing was chosen as an appropriate research method for this study. Interviews allow in-depth exploration of the topic and immediate clarification of issues (Holloway & Wheeler, 2002). Interviewing in qualitative research is a dynamic interaction between two people (Cormack, Gerrish & Lacey, 2006) and this would be lost if structured interviews had been used. Structured interviews are similar to spoken

questionnaires and so the respondent's views and feelings may not be fully captured. Unstructured interviews, on the other hand, contain very broad questions and there can be no guarantee that respondents will talk about similar issues (Burnard, 2005). For this reason, a semi-structured interview approach was adopted. Semi-structured interviews focus on the issues to be covered, but the sequencing of questions need not be the same for every participant and can depend on individual responses (Polit & Beck, 2006). However, care was taken that the interview fitted with a phenomenological approach, hence the questions used to focus the interview were very general in nature (see Appendix E). This ensured that participants were guided to the area to be studied, but not into pre-determined responses Whilst the interviews aim to gain participants' perspectives, some control of the interview is required so that the purpose of the study can be achieved (Holloway & Wheeler, 2002). By tape recording the interviews and transcribing, the interview can be read and re-read: only this way is it possible to identify all the relevant statements that may be made by the participants. Finally, it is important to remember that when interviewing someone with a terminal illness, one should stop at regular intervals to give them a chance to rest (Chapple, 2006). In this study, participants were observed for signs of tiredness during the interview.

Validity and reliability are often questioned in qualitative research, so this must be considered at the planning stage. Reliability refers to the consistency of a method in measuring or observing the same phenomena (Parahoo, 1997). Validity means measuring what was set out to be measured. Johnson (1997) argues that using extracts from participants' transcripts increases validity and reliability; by inclusion of these,

the researcher is demonstrating exactly what the participant said, and not their interpretation of it. Ensuring technical accuracy in the recording and transcribing stage is therefore vital (Perakyla, 1997). Transcribing was therefore carefully done on the day of the interview to avoid missing or misinterpreting statements. Interview questions were carefully planned to not lead the participant. Interview questions were examined by a third party to check their suitability, the aim being to encourage participants to give their own answers in their own words (Rose, 1994), and thus to enhance validity and reliability.

3.3 Questionnaires

Since the aim of the research is to unravel participants' feelings, it was felt that the use of a quality-of-life questionnaire would be informative. The questionnaire was completed before the complementary therapy commenced so that the researcher could compare the participant's perception of their quality of life, before therapy, with how they felt after therapy. It also gave some insight into the physical difficulties the participants faced and whether the therapy influenced this or not. The use of anxiety scales in palliative care was examined by Botting and Cook (1998), where it was suggested that studying quality of life through such scales allows patients to express how they feel about their treatment and their life situation. Four anxiety and depression scales were considered for this research. These were: The Hospital Anxiety and Depression Scale (HADS), The Geriatric Depression Scale (GDS), The Edinburgh Post-Natal Depression Scale (EPDS), and The European Organisation for Research and Treatment of Cancer (EORTC) Quality-of-Life Questionnaire. The HADS was eliminated due to the large number of questions it asked; these questions

only relate to feelings of depression or anxiety and not on other possibly significant symptoms such as pain and nausea. If the participant is having complementary therapy for pain relief then these latter symptoms are significant. The GDS was eliminated as it was felt to include questions inappropriate to ask palliative-care patients. For example, 'Do you think it is wonderful to be alive?' is not felt to be a sensitive question to ask someone who is dying. Surprisingly, the EPDS - whilst created to detect post-natal depression in women – is probably more appropriate here. The EPDS has been found to have a sensitivity of 70% and a specificity of 80% in patients with metastatic cancer receiving palliative care (Lloyd-Williams, Friedman & Rudd, 2000). It is also quick and easy to complete and therefore less likely to be viewed negatively by the patient. However the Research Ethics Committee overseeing this study felt it was inappropriate to use for this particular population. Further consideration determined that it would not have provided good information about how a participant feels in general, as it is only concerned with mood.

The EORTC questionnaire was therefore chosen as the most appropriate anxiety scale to use (see Appendix D[1]). The questionnaire is only two pages long and therefore is not time consuming to complete. It contains thirty questions in total, all of which are appropriate to ask a palliative-care patient. The EORTC questionnaire was also designed specifically to assess quality of life of cancer patients. It contains questions about how the person feels in general, whilst also asking about mood. Arguments against using the scale include the subjectivity of the final two questions, for example 'How would you rate your overall quality of life over the past week?'.

[1] permission was granted to use the questionnaire from the EORTC Quality of Life Unit in Brussels, and a user agreement was signed

However, feelings are by their nature subjective and the present study is concerned with those subjective feelings, hence the criticism does not apply. Use of this scale will enhance knowledge of the participants' perceptions of their health and difficulties prior to the study, and can be usefully compared to their post-therapy state. If the participant says anything at interview that contradicts their questionnaire responses, it can be clarified at interview to gain a more reliable response. Also administering the EORTC questionnaire after therapy was considered, but it was felt this would detract from the qualitative nature of the study. Whilst comparison of questionnaires pre and post-therapy would provide additional data, the research would then have been more quantitative and arguably less able to unravel the participants' feelings.

3.4 Participant Diaries

A further method utilised, which allowed triangulation, was the use of symptom diaries (see Appendix C for an example). A diary can be defined as a record of events, maintained by the subject over time, which is then collected and analysed by the researcher (Burns & Grove, 1987). A symptom diary may be used by a participant to record any information they feel is relevant to how they are feeling. It is considered a good way of capturing participants' feelings because it is completed each day rather than relying on memory. It is likely that participants would forget how they felt on a particular day if asked at a later date. Combining diaries and interviews in phenomenological research is not new but there is little literature that examines how to increase reliability and validity in this way (Clarke & Iphofen, 2006). Despite this, it is still thought that diaries allow the researcher an unobtrusive way of revealing the intimate areas of people's lives that may otherwise be hidden (Gibson, 1996). It was

decided to use diaries in the present study since some participants may not wish to talk about certain things, but may be willing to write them down. Elements of a participant's feelings that may be missed at interview may still be captured in their diary.

3.5 Sampling

In probability sampling – a typical method in quantitative research - the chosen participants must be representative of the wider population; the sample is therefore randomly selected from that population. Results from the sample can then be used to generalise about the population. In non-probability sampling a small selection from the population is chosen that have required characteristics. For example, in this study participants were eligible if they had a palliative diagnosis and were attending the Hospice as day-care patients; hence this sample is then representative of that smaller population, i.e. only those with a palliative diagnosis attending day care. Findings then only apply to the specific population under investigation (Higginbottom, 2004) which is the aim of the research here .

Sample size is determined by the need to fully investigate the chosen topic and to provide information-rich data (Grbich, 1999). Since this study aims to examine both acupuncture and aromatherapy, the sample should include a sufficient number of patients experiencing each type of therapy. Potential participants were drawn from the Hospice's complementary-therapy waiting list. Stratified random sampling was planned to be used to select the six required recruits: this involves separating out the important variables of gender, age and therapy type, and then drawing a sample from

each strata to ensure representation. However, since there was no waiting list, all those starting therapy were approached to take part. The method of sampling was therefore changed to quota sampling: Quota sampling is similar to accidental sampling in that only those available have a chance of being selected, but it allows the researcher to allocate places in advance (Parahoo, 1997). It was important in the present study to try to recruit participants for both acupuncture and aromatherapy to enhance reliability. Therefore, an element of quota sampling had to be applied and the study aimed to recruit three participants for each therapy studied. A sample of six patients was initially selected, a large enough sample for phenomenological research due to the in-depth nature of the interviewing (Higginbottom, 2004). Two to four additional participants would have been recruited if the first six did not provide enough data; these additional participants were not eventually needed.

4. DATA ANALYSIS

4.1 Analysis

Polit & Beck (2006) describe the purpose of data analysis as imposing order on a large volume of data. In qualitative research, the researcher needs to represent the thoughts and feelings of others in a systematic and honest way (Clayton & Thorne, 2000). Researchers use different methods to deal with data: the correct choice is important and must be consistent with the underlying philosophy and study methodology.

Qualitative research involves ongoing analysis and interpretation of information: decisions about further questions or observations are guided by this ongoing analysis (Polit & Beck, 2006; Walliman, 2001). Many qualitative researchers use the principle of 'saturation' to determine sample size (Parahoo, 1997; Tuckett, 2005). In this study six interviews were planned initially. However, if new themes had emerged up to four further interviews could occur, depending on when 'saturation' was felt to have been reached. Due to the loss of two participants, only four of the original six interviews were conducted. Data from five participant diaries was also available for analysis. By this point time constraints made further recruitment difficult. Whilst data from extra participants would have been useful, enough data was generated to produce valuable results.

A thematic approach was used to analyse the data, which was drawn mostly from verbatim interview transcripts but also from diaries. The interviews were transcribed on the day they were conducted to note body language or recall parts that may

eventually have been unclear on tape (following Silverman, 2005), and were listened to repeatedly to check the accuracy of the transcript (following Cohen, Kahn & Steeves, 2000).

It is important to organise data for qualitative analysis as a large amount is generated; a method of classification and indexing is needed. Since the number of interviews was only intended to be from six to eight a computerised method to aid data analysis (for example, software such as N-Vivo) was not considered necessary. Thematic analysis involves identifying emerging themes and categorising these themes using codes, colour coding of computer transcripts being used here. In the initial coding many researchers single out words or phrases used by participants. This helps prevent researchers from imposing their own ideas onto the data since the coding begins with the participants' own words (Holloway & Wheeler, 2002). Data analysis using this method is therefore not rigid, which helps since the way in which the data is best analysed often does not become apparent until data collection begins.

Data analysis began with the transcribed data from Participant #1. Participants were interviewed in order of when they were recruited to minimise the overall duration of the study. All statements which appeared relevant to the participants' perceptions of therapy were identified and highlighted as described above: a specific colour was assigned to statements which fitted any particular emerging theme. For example, statements relating to 'feeling relaxed' were highlighted in green. These statements were then separated from the interview text, and similar processing

performed on the subsequent participants[2]. By the final interview, an overall account of the phenomena under investigation could be produced. Participant diaries were also analysed thematically, in this case manually as the participants only made paper copies. The same colour codes were used as for the interview transcripts to avoid confusion. Any new themes which emerged and were not identified from interviews were assigned an additional colour code.

It is suggested by Priest (2002) that thematic analysis helps make one aware of prejudices and presuppositions that do not fit with one's views, so as not to reject certain statements. According to Williamson & Long (2005), organising the data in this way provides a logical chain of evidence enabling theoretical conclusions and their underlying rationale to be retraced. This augments the validity and reliability of the data. The process of bracketing was also used here (see Chapter 3). Bracketing is the process in which the researcher resolves to suspend their preconceptions so as not to reach conclusions before the participant's experience of reality has been revealed (Beech, 1999). This can be difficult to achieve since the researcher is only human and cannot readily forget everything they already know about a subject; only a 'best effort' is possible.

4.2 Ethical Considerations

Ethical issues must be considered prior to commencing any medical study. Ethical principles, and hence Research Ethics Committees, exist to protect the safety, dignity and wellbeing of research participants whilst facilitating and supporting

[2] Categorisation in this study was performed by text selection on computer. A paper-based method is also possible.

ethical research (National Patient Safety Agency, 2008). The Research Governance Framework for Health and Social Care (DH, 2005) state that researchers must seek advice to ensure their research is ethically sound. Research Ethics Committees have a responsibility to advise researchers and only allow research to commence when all steps have been taken to meet ethical principles (DH, 2005). Ethical approval was granted by the Faculty Research Ethics Sub-Committee, the Local Research Ethics Committee (LREC) and from the Hospice clinical sub-group committee. These committees scrutinised the purpose of the present study, the methods to be used and the way in which participants were to be recruited. They also ensured that the participant information sheet (see appendix A) contained all the necessary information, and that the consent form (see Appendix B) was appropriate. Advice was taken from the LREC with regard to which quality-of-life scale to use, and 'The Edinburgh Post-natal Depression Scale' was exchanged for the EORTC quality-of life questionnaire (see appendix D and Chapter 3 for further explanation).

Ethical principles which had to be considered in the planning of this study were: beneficence, non-maleficence, informed consent, equal opportunity and confidentiality (Clark & McCann, 2005). Beneficence refers to 'doing good' (Orb, Eisenhauer & Wynaden, 2001). This research aims to do good by providing evidence of whether acupuncture and aromatherapy is beneficial or not in palliative care and can be used to inform the provision of complementary therapies; it would be unethical to involve a patient in research if no benefit is expected for them and future patients (Gelling, 1999). Non-maleficence refers to 'doing no harm'. This is more difficult to establish in a study where patients discuss their feelings. Interviews require patients to

think or talk about aspects of their life, care and illness, which may be new or threatening to them (Jannett, Payne & Wiles, 1999). In this study, it was planned that interviews would be postponed or abandoned should the participant become distressed. Palliative-care patients may have 'good days' and 'bad days', therefore interviews did not commence if the participant perceived they were having a 'bad day'. Participants were reassured that if they did not feel well on the day of interview they could cancel and rearrange.

It is important as a researcher to demonstrate skills of empathy, listening, sensitivity and diplomacy (Seymour, Payne, Reid, Sargeant, Skilbeck & Smith, 2005); therefore should the participant become upset during interview the interviewer would spend time listening to their concerns whilst abandoning the interview itself. There is potential maleficence for those who take part, in that patients are discussing sensitive issues, so care was taken to be sensitive to verbal and non-verbal cues - which may indicate distress - and to respond appropriately. Should any participant demonstrate severe psychological distress, they would be referred back to the Hospice for appropriate counselling by a qualified professional.

Ongoing informed consent is needed from a person participating in any research, after risks, benefits and alternatives have been adequately explained to them (Royal College of Nursing, 2004; 2005). Participants had risks, benefits and alternatives explained to them in the participant information leaflet. The information has to be understood and sufficient for the patient to make an informed decision (Lesage & Portenoy, 2001) hence the information leaflet is written to make it easily understood by a lay person (see appendix A). It was intended that potential participants would be

given the leaflet to take away and read in their own time before consenting to participate. There was no coercion to take part, and the therapy of those who did not participate was unaffected. The researcher answered questions from potential participants. Patients were excluded from the study if they were confused, as informed consent requires understanding (RCN, 2005).

It is important to provide an equal opportunity to all patients to participate. All patients about to commence acupuncture or aromatherapy at the Hospice were asked to participate, but were only approached if the staff there believed they were well enough (following Wilkie, 2001). The sampling technique used to recruit is described in Section 3.5, and ensured that all patients had an equal opportunity to participate.

Finally it is important to reassure potential participants that their participation will be confidential and that they will remain anonymous when the results are published: this is stated in the patient information leaflet (see appendix A). Patients were referred to by number only on any data obtained from them (i.e. diaries and interview transcripts). The only information that contained their name is their consent form; this was stored in a locked cupboard in a secure location (following RCN, 2004).

5. RESULTS

Participants were recruited between July and November 2007. Interviews were conducted between October 2007 and January 2008. Full results (interview data, participant diary and EORTC questionnaire data) were obtained from four participants. In addition to this a fifth participant diary was available for analysis. Participant #5 unfortunately became too ill to be interviewed. Participant #6 had missed many sessions of therapy and no longer wanted to be involved: this decision was respected. It should be noted that people agree to participate in research for a number of reasons (Peel, Parry, Douglas & Lawton, 2006) and if in their view participation offers no benefits participants may change their mind (Ross, Triggs, Cadbury, Axford & Victor, 1998).

5.1 Participant profiles

Details of the six recruited participants are summarised in Table 1. Recruitment of these participants was done to ensure a mix of male and female, and to have an equal number having acupuncture and aromatherapy. Unfortunately the two participants who failed to complete the research were both having acupuncture. This left only one participant having acupuncture to interview, although two acupuncture diaries were available for analysis. Participants varied in age between fifty-nine and seventy-four with the mean age being sixty-nine.

Table 1: Summary of study participants, in the order they were recruited. Participants #5 and #6 did not complete the study, and were not interviewed.

Participant	*Sex*	*Diagnosis*	*Therapy*
1	Female	Ovarian cancer	Acupuncture
2	Female	Metastatic breast cancer	Aromatherapy
3	Male	Multiple metastasis, possibly including cancer in the groin	Aromatherapy
4	Female	Breast cancer	Aromatherapy
5	Male	Lung cancer	Acupuncture
6	Female	Unknown	Acupuncture

5.2 Reasons given for trying acupuncture/aromatherapy

Reasons given for having the therapies were varied (see Table 2), but pain relief was commented on at interview by all four participants interviewed. The relief of stress and the promotion of general wellbeing were also mentioned as reasons for having a complementary therapy.

Table 2: Reasons given for trying acupuncture/aromatherapy.

Participant	*Reason for trying acupuncture/aromatherapy*
1	"I wanted more movement and less pain."
2	"I'd try anything that I think has a chance of working, if people who've had similar types of pain or stress suggest things to me then I'll have a go because you never know what's gonna work."
3	"I tried it for the tension in my neck and for general wellbeing, I didn't know what it could help with."
4	"I just wanted a bit of relief from the pain and some relaxation."

5.3 Feelings prior to commencing acupuncture/aromatherapy:

5.3.1 EORTC quality-of-life questionnaire

Much of the data regarding feelings prior to therapy was obtained from the EORTC quality-of-life questionnaires. All participants felt that their quality of life was limited in some way. The following extracts demonstrate this:

Participant #1:

> *Felt that her overall quality of life during the previous week had been fair. Despite this she was troubled 'very much' by nausea, with feelings of weakness, constipation and tiredness. She was also troubled 'quite a bit' by tension, worrying and had trouble sleeping.*

Participant #2:

> *Rated her overall health over the past week the lowest and was troubled 'very much' by symptoms of shortness of breath, nausea, constipation, lack of appetite and inability to sleep. In addition to this she was troubled 'quite a bit' by pain and by her difficulty remembering things. Despite this she rated her overall quality of life as moderate.*

Participant #3:

> *Felt that his overall quality of life was moderate. He was troubled 'very much' by lack of appetite and 'quite a bit' by nausea, constipation, his trouble sleeping and his difficulty remembering things. He felt that his physical condition interfered with his social activities 'quite a bit' and prevented him from taking a long walk.*

Participant #4:

Based on the EORTC questionnaire, she had less troubling symptoms than the other participants. She had pain and shortness of breath 'quite a bit' and was troubled 'a little' by tiredness and with her difficulty remembering things. She rated her overall quality of life as good.

Participant #5:

Rated his overall quality of life as poor and was troubled 'very much' by symptoms of shortness of breath and constipation. He was troubled 'quite a bit' by pain, weakness, tiredness and his difficulty remembering things.

In the questionnaire, all participants reported being limited in their daily activities. Strenuous activities and taking a long walk were problematic for all. Some of the problems stated in the questionnaire do not coincide with the information given at interview.

5.3.2 Interview notes

Participant #1:

Complained of feeling weary and tired all the time: "The main thing that affected me was the weariness and tiredness. I just couldn't cope with that. I mean, I could sit down and just want to sleep and couldn't do very much because I got so tired". Another point she made was feeling more emotional: "I'm quite emotional now, and probably things that wouldn't have affected me before affect me now".

Participant #2:

Emphasised the pain and stress as being her overwhelming feelings prior to therapy: "I was completely stressed out by the radiotherapy, really climbing the walls, couldn't concentrate more than anything else and just couldn't relax enough to get a grip on things". "I was in a lot of pain, somewhere between my head and my toes".

Participant #3:

Complained of feeling tired and generally unwell. Loss of appetite was a worry for him. Pain, however, was not an issue: "I didn't feel very good, no energy, very tired. But I didn't have any pain, just feeling lousy all the time." "It's all the chemotherapy, it really affects your taste and your appetite."

Participant #4:

Felt generally well but did state anxiety and pain as being problematic at times: "I just felt anxious with all the problems and a bit low sometimes with the pain from the arthritis."

Participant #5:

Was too unwell to be interviewed and so data is not available.

Participant #6:

Did not wish to be interviewed.

Some similarities exist between the EORTC data and the interview transcript data but there are also some discrepancies. This confirms that it was useful to use more than one method for data collection; sometimes participants may forget to mention something at interview but find it easier to remember when asked in a questionnaire. Participants may also find some symptoms too embarrassing to talk about at interview. For example, three participants mentioned in the questionnaire that they were troubled with constipation yet none mentioned that during their interview. Since the EORTC questionnaire only asks about symptoms experienced within the last week, it is possible that some participants did not experience certain symptoms in that particular week that they later mentioned at interview. For example, Participant #4 stated in the questionnaire that she had not felt tense, worried, irritable or depressed, yet at interview she stated feeling anxious and 'a bit low'. People can be inconsistent

in what they say, which is why it is important to clarify their responses at interview (Burnard, 2005).

5.3.3 Themes identified at interview

Using thematic analysis, as discussed in the data analysis section, the following themes were identified from the interview transcripts:

- Therapies helped with pain.
- Therapies promoted relaxation.
- Therapies allowed 'me time'.
- Participants valued the counselling role of the therapist and the hospice setting.

Each theme will now be examined in turn.

5.4 Pain

From the EORTC questionnaire and the interview transcripts, pain was found to be an issue for some of the participants. Pain in palliative care is known to be an issue: one-third of patients with cancer will experience pain, this increases to two thirds when the patient becomes palliative (Schofield et al., 2007). Participants were not asked about their pain as this would have been a leading question and therefore not within a phenomenological methodology. However, all participants chose by themselves to discuss the pain relief element of their chosen therapy.

Table 3: Comments made regarding pain.

Participant	*Comments made regarding pain relief*
1	"I don't have the same pain in it, I mean I'm sitting just now relaxed whereas before I had the treatment (acupuncture) it was very painful, it's not painful now, I am aware of it but I mean it's not painful whereas before you tended to say that's really sore so I think from that point of view its probably been a success."
2	"It hasn't actually helped with the pain but what it has helped with is being able to live with the pain, in that sense, it's certainly done that."
3	"I've got less tension in my neck. I can appreciate now that my neck is a lot better so that is an ongoing thing I think."
4	"I did get relief from the pain for quite a few hours but there again I don't know whether it's psychological or it's because you're having that movement of your muscles and it increases the circulation I suppose. I think it certainly does make a difference."

These responses regarding pain relief were obtained from three different questions. Participants #1 and #3 discussed pain when asked 'How long did the effects of the acupuncture/aromatherapy last?' Participant #2 discussed her problem with pain when asked 'How did you feel before the therapy started?', and when asked 'Why did you decide to try aromatherapy?' she stated that it was mainly to control her stress, 'because if you can control the stress you can control the pain'. Her particular pain was arthritic and she felt that stress made it worse. She also had chest pains after radiotherapy which she wanted to try and improve. Participant #4 discussed pain when asked 'Why did you decide to try aromatherapy?' None of these questions prompted the participants to talk about the pain-relieving aspect of their therapy.

Pain relief can be physical or psychological ,and this was acknowledged by some of the participants. In the above statement, Participant #4 stated that she didn't know whether pain relief was psychological or from having her muscles manipulated, but 'either way it worked'. Participant #2 felt that pain relief also had a psychological

element in that it was connected to her stress levels. Participant #1 felt that her muscles were less sore, and so believed that the therapy had a physical benefit. Participant #3 felt the tension in his neck had improved, but did not indicate whether he felt that this was a physical improvement. Participant #1 mentioned having had a cortisone injection in her shoulder at the end of her acupuncture sessions. It is therefore difficult to link her reported improvement in pain at interview to the acupuncture. Although she felt it was probably the acupuncture, it can only be speculated whether this is actually true.

5.5 Relaxation

All participants spoke of the relaxing element of having their therapy. Sample statements are given in Table 4.

Table 4: Comments made about relaxation.

Participant	*Comments made regarding relaxation*
1	"It was quite soothing and kind of relaxes you and it kind of took all the tension away."
2	"I could feel the tension drain out. The smell of the oils is very relaxing."
3	"It's a lovely feeling really relaxing for about 20mins. I can't say it's helping my problem but its certainly relaxing me."
4	"I found the whole experience very calming, very relaxing."

Participants differed in how long they felt the feeling of relaxation lasted. Participant #3 stated that it lasted for a few hours whereas Participant #2 felt that she relaxed enough to cope with the rest of the week:

"You just relax to the stage where you think, 'Yeah, bring it on I can cope with it.' I wouldn't like to but it's a feeling you get that you can cope with the rest of the week now."

Participant #1 did not mention how long she felt relaxed after therapy but did state that she felt 'in tension' all the time at home, and that it only eased off when she spent time at the Hospice. Participant #4 was unsure how long the relaxing effect lasted but felt it was always there at the back of her mind, which in turn made her feel more positive:

"I can't say it stayed with me for the full week but it was there at the back of your mind that it was relaxing."

The relaxing element of the therapy was discussed by three of the four participants when asked, 'How did you feel during the therapy session?' The only participant who did not mention relaxation when asked this question was Participant #1 who was the only interviewee to have acupuncture. This suggests that aromatherapy massage is relaxing at the time of therapy whereas acupuncture may not have the same effect at that time. However, Participant #1 did mention the relaxing element of acupuncture when asked, 'What did you like the most about the therapy sessions?' This suggests that although she did not feel relaxed during the session, overall she thought that having the therapy did elicit feelings of relaxation.

5.6 'Me time'

Having time for themselves was mentioned by all three female participants. They valued their therapy because it was a time set aside for them to be pampered and looked after. Typical comments are given in Table 5.

Table 5: Comments made regarding 'Me time'.

Participant	*Comments made regarding 'Me time'*
1	"It was nice to have someone giving me some attention instead of me having to give it to other people." "I enjoyed the one to one, probably childish and selfish but there again I just needed it."
2	"I think the whole thing was the fact that this is devoted to helping me."
3	No comment made.
4	"You do feel a little better whether it's because of the treatment or whether it's because you're getting that hands on and somebody's doing something for you, I don't know." "I think it's just because you've got somebody there with you and attending to you and a bit of hands on, doing something for you."

This theme differs to the others in that not all respondents mentioned the importance of 'me time'. Three of the four participants discussed valuing the 'hands-on' and the attention. Interestingly, the only male to be interviewed was the only respondent not to mention the value of 'me time'. Participants #1 and #4 discussed me time when asked, 'How did you feel during the acupuncture/aromatherapy sessions?' Participants #2 and #4 mentioned it when asked, 'What did you like the most about the aromatherapy sessions?' This suggests that the females felt that they have less time to themselves in their day-to-day lives. Participant #4 mentioned always doing things for other people and saw her therapy as her time to have the attention. However, a conclusion cannot be drawn since there was only one male respondent

and a small sample of females. It does, however, highlight an issue of interest for future study.

5.7 The counselling role of the therapist and hospice setting

The hospice setting was valued by all female participants, and in particular the counselling role of the therapist. Participants felt they could easily talk to the staff at the Hospice about things that were worrying them and that the staff would do all they could to help. One participant felt that at her stage of her illness she would be too embarrassed to seek complementary therapies from anywhere other than the Hospice. She felt that the staff there understood and were not shocked by her physical appearance. Participants valued the therapist's caring attitude towards them. Typical comments are given in Table 6.

Table 6: Comments made regarding counselling role of therapist/ hospice setting.

Participant	***Comments made regarding counselling role of therapist/ hospice setting***
1	"I think probably the hospice staff are different, they don't make you feel like you're a nuisance, you could tell them anything that was worrying you and they would try and help."
2	"I think a lot of the help is actually the hospice setting because I don't think you'd go out and go somewhere and have this at this stage *(of her illness),* I don't think I could." "When you go to the hospice, it's holistic rather than just a treatment because when you go in they want to know how you've gone on, how was your week, how you feel, if anything is stressing you out and that's as much a treatment as what you're going to have."
3	No comment made.
4	"There's someone there to talk to and ask about things, if you've got any problems you can just ask."

Again there appears to be a gender divide in how participants perceive the counselling role of the therapist. Participant #3 (male) did not mention this whereas

all three other participants (female) did. Participants #1, #2 and #4 all discussed this at different points of the interview. Participant #1 did so when asked, 'How did you feel during the acupuncture sessions?' Participant #2 mentioned this when asked, 'Would you consider aromatherapy again in the future?', and Participant #4 mentioned this when asked, 'How did you feel the day after each aromatherapy session?' This confirms that the questions were not leading.

All participants were asked the same questions (See Appendix E for interview questions). Some participants were more talkative than others and prompts were used if required: for example 'Can you tell me more about that?', and 'What do you mean by that?' were questions used to encourage deeper conversation. The questions and prompts were carefully considered before interview to ensure they would not lead the participant's response. Prompts also enabled the researcher to check their understanding of the responses to minimise misinterpretation of information.

5.8 Other information obtained at interview

A lessening in tiredness was mentioned by Participant #4. When asked, 'How did you feel before the aromatherapy?', she said she felt tired all the time; she then said she felt a little better after the therapy. She acknowledged that this may have been psychological but was happy that it had worked:

"It gives you time to have a little snooze."

Two of the four participants mentioned feeling initially worse the day after their first therapy session. Participant #3 put this down to manipulation of muscles that had not been manipulated before. However, this had improved by the following day and

did not occur again. Participant #2 described the day after the first session as 'a bad day' because all the tension was 'dripping out of her'. She felt this was a positive thing because it improved how she felt for the rest of the week.

5.9 Daily diary analysis

5.9.1 Participant #1

Table 7: Participant #1 schedule.

Week	***Therapy schedule***
1	1st acupuncture session
2	2nd acupuncture session
3	3rd acupuncture session
4	No therapy, as therapist on holiday
5	4th acupuncture session
6	5th acupuncture session
7	No therapy, as away on holiday
8	No acupuncture

Following the first acupuncture session Participant #1 reported pain for the rest of that week; she also reported feeling low the day prior to session two. Immediately after the second session she reported feeling less pain; she also reported the pain being lessened two days afterwards. However, she reported pain on days four and five after therapy. Following session three she reported: 'not sure if treatment is helping'. Pain was reported on days three, four, six and seven of the week. Therapy was not available during week four and by the end of that week she reported feeling desperate for treatment, stating "it always feels better, although not for long". Following session four she felt better on the two days after therapy; she did not elaborate in what way she felt better. Following session five she reported that her shoulder felt easier. Later that week the pain returned but she put this down to having taken a long car journey.

She missed week seven due to being on holiday and documented that she missed having the treatment. From her daily diary it is evident that she did not think the therapy was helping up to week three, yet by week five she missed not having it. This may be because it took a few sessions to notice any improvement. By week five she had not yet had her steroid injection and so it could not have been this that was starting to alleviate her symptoms.

5.9.2 Participant #2

Table 8: Participant #2 schedule.

Week	***Therapy schedule***
1	1st aromatherapy session
2	Did not attend for therapy as unwell
3	No hospice therapy as participant on holiday but did pay to have a massage whilst away
4	No therapy, still on holiday
5	2nd aromatherapy session
6	3rd aromatherapy session
7	4th aromatherapy session
8	5th aromatherapy session
9	6th aromatherapy session

After session one of the aromatherapy she reported feeling relaxed and pain-free. The following three days she required pain relief during the night. Week two was missed due to feeling unwell, but she used oils at home and reported feeling more relaxed. Weeks three and four were missed due to being on holiday, but whilst away she had a massage and stated this helped her relax, and alleviated the pain. The day after session two she reported feeling 'unwound' and generally better. In the two days prior to session three she reported having to stay in bed due to pain. In contrast, the day after session three she felt tired but pain-free. At session four she reported immediate relief from pain; this improvement lasted for four days. Following session

five she felt relaxed and following session six she had less pain. At every session an improvement was reported and so it would appear that aromatherapy was highly beneficial to this participant. It is important to note that when she used oils at home she reported feeling more relaxed. However, it was only when the oils were combined with massage that she reported feeling pain-free as well as relaxed. This suggests that the oils and the massage each have an effect but when combined the effect is stronger.

5.9.3 Participant #3

Table 9: Participant #3 schedule.

Week	***Therapy schedule***
1	1st aromatherapy session
2	No therapy, attending hospital
3	No therapy, attending hospital
4	No therapy, attending hospital
5	2nd aromatherapy session
6	3rd aromatherapy session
7	4th aromatherapy session
8	No therapy, therapist on holiday

Reported feeling more relaxed following session one of aromatherapy but was still in pain. Interestingly, this participant reported no pain in the EORTC questionnaire and at interview said he had no pain prior to starting therapy. This may be because he often describes it as a burning sensation which he attributes to the chemotherapy; he had only completed chemotherapy shortly before his aromatherapy commenced. Weeks two, three, four and five were missed due to having radiotherapy. During this time he reported feeling 'up and down'. Following session two he reported having more energy. Following session three he stated he enjoyed the therapy and felt more relaxed. At week eight the therapy was cancelled and he stated "I'll miss it, it relaxes me". No further therapy sessions were recorded in his diary.

Data from this diary is limited due to the amount of sessions missed. However, it is clear that on the therapy days he felt more relaxed and enjoyed the aromatherapy.

5.9.4 Participant #4

Table 10: Participant #4 schedule.

Week	***Therapy schedule***
1	1st aromatherapy session
2	2nd aromatherapy session
3	3rd aromatherapy session
4	No therapy
5	4th aromatherapy session
6	5th aromatherapy session
7	6th aromatherapy session
8	7th aromatherapy session

Only a small amount was written in her diary. However, after each session she reported enjoying the therapy. After three of the seven sessions she reported feeling relaxed. Although she did not report an improvement in pain after each session, she wrote at the end that the therapy had 'certainly helped with the pain'. On two occasions she reported pain three days after therapy and on one occasion five days after therapy. On the day of massage she reported feeling better after five of the sessions (three sessions due to pain relief and two sessions due to feeling relaxed)

5.9.5 Participant #5

Table 11: Participant #5 schedule.

Week	***Therapy schedule***
1	1st acupuncture session
2	2nd acupuncture session
3	3rd acupuncture session
4	4th acupuncture session
5	5th acupuncture session
6	No therapy, therapist on holiday

The diary is the only information available from this participant. Following session one he reported a reduction in pain and stated he did not need to take any medication. The day after the therapy was also reported as a good day. His pain returned the next day (two days post-therapy) and continued until the next session. Following session two he reported a great improvement in pain; this time the improvement lasted for four days. Again after session three he reported a great improvement in pain. Although the remainder of the week was not good, pain was not the issue: he felt tired, dizzy and nauseous. The day of session four was reported to be a very good day; however, pain returned the following evening. For the rest of the week he reported tiredness as a problem and mentioned having to take analgesia on two occasions. Following session five he reported less pain. For the remainder of the week pain was not mentioned as an issue, just feeling tired. From this diary it would appear that on the day of each acupuncture session, the participant had a noticeable reduction in pain. Although he could not be interviewed to clarify this, the diary was completed comprehensively and so provides some evidence of a link between acupuncture and pain relief.

5.9.6 Participant #6

Participant #6 did not keep a diary.

5.9.7 Summary

Overall, the use of triangulation has proved beneficial. The diaries have been useful for pinpointing exactly when the participants felt an improvement or not and how many sessions were needed before a benefit was felt. Interviews, on the other hand, yielded more in-depth data about the participants' feelings. Both methods have

provided consistent data and have complemented each other's findings. This has enhanced validity and reliability.

6. DISCUSSION

In this chapter the findings are compared to the literature reviewed prior to commencing the research. Each theme will be discussed in turn with aromatherapy and acupuncture being discussed separately.

6.1 Pain and aromatherapy

Three studies examined in the literature review found aromatherapy to be linked to a reduction in pain. Evans (1995) found a reduction in pain post-massage by conducting an audit and asking participants after their therapy if they felt better, worse, or the same. All three participants in the present study who had aromatherapy discussed the pain-relieving effect it had. In a randomised control trial, Soden et al. (2004) reported a statistically significant reduction in pain following aromatherapy. Identifying statistical significance is not the aim of the present study but it has identified a reduction in pain following aromatherapy: from the daily diaries, there is a noticeable reported reduction in pain immediately post-massage. Participant #1 reported a reduction in pain following every massage. Participant #4 stated at the end of her diary that it had helped with the pain, although she did not specify after which sessions this had occurred. Participant #3 did not specify in his diary that there was an improvement in pain post-massage but did mention at interview that it had helped with the pain. It may be that he did not find an immediate improvement and so did not link it to the massage at the time; however, over the weeks he appreciated that his pain had improved. This suggests that for some patients it takes several sessions to feel a benefit whereas others (e.g. Participant #2) felt the benefit straight away. Wilkie et al.

(2000) found an improvement in pain after the first and third massage but not after the second and fourth. The present studies findings are not the same as in Wilkie et al. (2000): one of the three participants reported a reduction in pain after all therapy sessions and one of the participants reported an overall reduction in pain, although did not specify when the improvement was noticed. Participant #3 discussed pain very little but did state he had pain following session one. At interview he stated an overall improvement in pain and said he could only appreciate that it had helped with the pain once the sessions had stopped.

The results obtained emphasise that everyone is different: pain is individual and will vary in location and intensity depending on diagnosis, stage of the disease and individual tolerance of pain. This multidimensionality of pain makes it difficult to compare palliative-patients' experiences (Bostrom, Sandh, Lundberg & Fridlund, 2004). Whilst studies differ in their findings of when pain is improved, it is relevant that many studies do report a reduction in pain at some point during therapy.

6.2 Pain and acupuncture

In the present study both participants that had acupuncture reported an improvement in pain. This reflects the findings of Leng (1999) who studied forty-seven patients treated with acupuncture at a hospice. Of these, fifty-five percent reported a reduction in pain. However, other studies reviewed disagree with these findings. Lee, Schmidt & Ernst (2004) examined acupuncture for the relief of cancer-related pain and their results did not demonstrate its effectiveness. Gadsby et al. (1997) examined acupuncture-like nerve stimulation and concluded that symptoms of

pain were not improved; only the EORTC questionnaire was used in the Gadsby study. As the present study has discovered, the use of multiple methods enhances results. The days in which pain was reported to be better in the diaries makes it possible to identify a link between acupuncture and pain relief. The present study has more positive results than the literature reviewed, perhaps due to its qualitative design.

It must be remembered that the pain experience is the end result of a complex process; studies have shown that pain is influenced by patients' thoughts, beliefs and previous experience (Bostrom, Sandh, Lundberg & Fridland, 2004). It can result from the actual physical condition of the patient or from the psychological distress arising from a palliative diagnosis: if we don't know what causes pain, it is hard to work out how to alleviate it. Whilst it may appear that there is an improvement in pain post-therapy, other influencing factors must be taken into consideration. For example, was the patient expecting to feel better post-therapy due to previous successful therapies? With the benefit of hindsight, it would have been useful to ask about previous experience of therapies during the interviews. Also, whilst some participants have documented the days in which they took analgesia, not all did: it would be significant if any analgesia was taken on the days participants reported less pain. From the data obtained, relaxation and pain relief appear to go hand-in-hand, suggesting a strong psychological element to pain. As suggested by Participant #2, it may be that feeling relaxed helps to cope with pain but does not actually improve the pain itself.

6.3 Relaxation and acupuncture

Acupuncture was not reported in the diaries to be relaxing (participant #1 and #5) However, it was reported at interview (Participant #1) to have a relaxing effect and to take the tension away. This could be because pain was her biggest issue and she concentrated on this in her diary. None of the studies examined in the literature look at the relaxing effect of acupuncture; it is therefore impossible to agree or disagree with previous studies, merely to recommend further investigation.

6.4 Relaxation and aromatherapy

All participants in the present study spoke of the relaxing effect of the aromatherapy and documented it several times in their diaries; this reflects the findings of other studies. Previous studies have found a link between aromatherapy and a reduction in anxiety (Wilkinson et al., 1999; Soden et al., 2004) but these have been quantitative (using anxiety scales); anxiety and relaxation are related but however are not identical concepts. Whilst it may be the relaxation of the therapy that helps to improve anxiety, there may be other influencing factors. Participants in a study conducted by Dunwoody, Smyth & Davidson (2002) liked the de-stressing effect of aromatherapy, as did Participant #2 in the present study. In some previous quantitative studies (e.g. Wilcock et al., 2004) participants chose to continue with aromatherapy because it made them feel relaxed, despite the study measuring no statistically significant difference. From the literature a link can be made between aromatherapy and a reduction in perceived anxiety; the present study provides evidence that indicates this link.

Like pain, relaxation means different things to different people. Participant #1 felt relaxed simply by being away from home and in the hospice setting. It is possible that it was not the acupuncture itself that enhanced her relaxation, simply the time out from everyday life. Therefore the four identified themes (pain relief, relaxation, 'me time' and counselling) may be inter-related. The hospice setting and 'me time' enables the participant to feel more relaxed, thus improving pain. Participant #2 clearly felt that the actual massage and use of oils enhanced her relaxation: this she confirmed by stating she felt relaxed when using oils at home (it may be the smell of the oils that causes relaxation or something as simple as the use of relaxing background music during massage, although none of the participants mentioned whether this was the case). There is no evidence that the use of oils improves the physical effects of the massage (e.g. Maddocks-Jennings & Wilkinson, 2004) but psychologically the effects are not known.

6.5 'Me time' and aromatherapy

The importance of 'me time' was only apparent from the interviews; it is not something mentioned in the diaries. This may be because it required a more in-depth qualitative approach to unravel these feelings. It is a theme not readily apparent from examining the previous literature, although Dunwoody, Smyth & Davidson (2002) discuss a similar concept where aromatherapy is viewed by the participants as a 'reward' after harsh conventional treatments. All the female participants mentioned the value of having time for themselves to be looked after. Further research is needed to examine this theme further and to examine the gender difference that appears to exist.

6.6 'Me time' and acupuncture

Again, the value of 'me time' is not apparent in the literature. Previous studies have examined acupuncture with regard to specific symptoms. The present study looks qualitatively at the holistic needs of the participants and as a result their feelings have been captured. Whilst having 'me time' is not a symptom to be improved (like pain), it has been highlighted as important by the participants and so is important in palliative care. Participant #1 mentioned how she enjoyed 'me time' twice during the interview and she felt having the acupuncture gave her this time. Further evidence is required as data from only one participant was available.

6.7 Counselling role of therapist/hospice setting, and aromatherapy

The counselling role of the therapist is not a previously well-documented theme; only Dunwoody, Smyth & Davidson (2002) mention that their participants valued counselling. In the present study, three of the four interviewed participants spoke about how they valued having the therapist to talk to and valued the comfort of the hospice setting. There may be a gender divide in this view as the male participant interviewed did not mention it, but a conclusion is difficult due to the small sample size. Many hospice patients are elderly and have never sought counselling (Heyse-Moore, 2007). Talking informally may be more acceptable to them, as a part of their daily care. Patients often feel they should be strong for their families when at home, but can reveal their worries at the hospice.

6.8 Counselling role of therapist/hospice setting, and acupuncture

Acupuncture has traditionally been examined in relation to its benefit for specific symptoms. Hence the literature reviewed has not mentioned the value of the therapist's role and the hospice setting. Despite this it was mentioned by Participant #1 at interview: to her, the therapy session was a chance to talk about her worries and this enhanced her wellbeing. Communication is a vital component of palliative care (Thomas, 2005; Green, 2006) and so it is logical that patients value the counselling role of the therapist.

6.9 Summary

The themes of pain and relaxation are apparent in previous literature (Evans, 1995; Soden et al., 2004; Wilkinson et al., 1999; Wilcock et al., 2004). The present study strengthens this evidence base. The themes of 'me time' and the counselling role of the therapist were only mentioned in one study (Dunwoody, Smyth & Davidson, 2002). Further research is needed to enhance the evidence for these two themes.

6.10 Strengths and Limitations

The limitations found in the present study will be discussed in the order they became apparent. All research has strengths limitations, and it is important for researchers to discuss the strengths and limitations of a study so that others are aware of them and can judge the study's credibility (Vivar, 2007).

The study was originally entitled "Patients' perceptions of the benefits of complementary therapies in palliative care". However, it was later realised that such a title does not lie within a phenomenological approach and could 'lead' the participants, because it infers that the researcher expected the therapy to be beneficial. The participant information sheet (see Appendix A) did contain the original title, and this was approved by the Local Research Ethics Committee and was subsequently given out to the participants. However, after this the potential for benefit was not mentioned to the participants; interview questions were carefully planned to ensure a fit with a phenomenological approach (see Appendix E). Future research will take account of the underlying philosophy early in the planning stage.

Recruitment was a time-consuming process. Upon commencing patient recruitment it became apparent that the Hospice did not have a list of patients waiting to start either acupuncture or aromatherapy. Therefore, there was no option but to wait for patients to be referred for, or to request, either acupuncture or aromatherapy. Unfortunately, two months after recruitment commenced only two patients had consented to take part. One problem was that Hospice staff did not want to approach patients who were new to the Hospice to take part. The Day-Care Sister in charge felt that new patients needed time to settle in and to get to know the staff before being asked to participate. This was not something the researcher was aware of upon commencing this study, and it often meant that patients had already started a therapy and so could not participate; since new patients often attended the Hospice specifically for complementary therapies the Sister's actions made it difficult to recruit. There are numerous examples of palliative-care studies failing to recruit

sufficient patients; they typically have high attrition rates and have missing data (Addington-Hall, 2002). Once this difficulty was realised, the recruitment process was reviewed, and it was decided that the Hospice staff would invite any of their regular patients to have either aromatherapy or acupuncture. Only if they agreed to the therapy were they then asked to participate; this ensured they actually wanted the therapy to help with their symptoms. It was felt that this approach was within the approval given by the Research Ethics Committee because all patients at the Hospice were asked anyway if they wanted to try a therapy, and so all therefore had an equal opportunity of selection into the study. Advice from the University was nevertheless taken at this point to ensure the ethical approval still applied.

To limit recruitment problems in future research it would be beneficial to involve a chosen hospice in the early stages of planning a study: communication with its staff could indicate possible problems with recruitment, and ways to overcome them.

Pilot studies are useful for ensuring the questions asked will provide information-rich data. It is also useful practice - especially for the novice researcher - to identify where modifications are necessary for later interviews (Vivar, 2007; Rose, 1994). Each interview only happens once so one must have the ability to 'home in' on chance remarks where further probing may produce a wealth of extra data. However, due to recruitment difficulties the researcher was unable to conduct a pilot interview; this meant that the researcher was a novice when conducting the first interview. Nevertheless, there was as much data from the Participant #1 interview as from the others and so not conducting a pilot interview did not seem detrimental to the overall results.

A limitation in this study was that one participant dropped out completely and another became too unwell to be interviewed; this limited the results to five diaries and four interviews. This is to be expected in research on palliative-care patients; a palliative-care patient's condition can change very suddenly and the progression of disease in each patient is different (Thomas, 2005). With hindsight more patients should have been recruited at the start: there was not enough time for additional recruitment once participants had dropped out. Any further research will plan for this likelihood; it is better to have too much data than not enough. The validity and reliability of this study could be questioned due to the small sample size. However, qualitative research can make use of small samples and does not claim to be generalisable.

A notable strength is the use of triangulation as a method. As discussed in previous sections, each method yielded different information which allowed for more in-depth analysis than could have been gained from one method alone.

This study yielded interesting results which enabled the aim of the research to be achieved. The findings contribute to the body of knowledge regarding complementary therapies in palliative care and will aid readers in developing an understanding in this area.

7. CONCLUSIONS

It is useful to revisit the aim of this study to decide if it has been met: this was "To explore perceptions of acupuncture and aromatherapy as experienced by palliative-care patients attending a day hospice". Since this study was always intended to be a small qualitative study, it has achieved its aim. The perceptions of five palliative-care patients have been explored, four through interviews and diaries, and one through a diary alone.

Interesting results have been obtained. The research uncovered four main themes: that therapies helped with pain; that they helped with relaxation; that they provided 'me time'; and that the therapist provided a counselling role in a comfortable setting.

Two of these themes are recurrent in the literature: pain and relaxation. However, the themes of 'me time', and the counselling role of the therapist, are not apparent in the literature. These latter two themes are less widely studied as it is more difficult to prove a benefit to patients, whereas improvements in pain and relaxation can be more easily studied and quantified. Whether the patient benefits from the 'me time' and from the counselling appears to be individual, but since palliative care aims to be holistic and be based on individual needs, these two themes are important and require further investigation. All participants stated that they enjoyed their therapy and would have further therapy in the future. This by itself supports the view that to achieve holistic palliative care, therapies such as acupuncture and aromatherapy should be offered to patients.

Triangulation has proved useful in this research as the interviews and diaries yielded different yet complementary information in some cases, and the EORTC questionnaire provided useful information on the symptoms the participants had before the therapy. This enabled the researcher to establish what symptoms the participants were hoping to improve. Use of these methods adds to the validity and reliability of the research findings.

It is clear that patients' perceptions of acupuncture and aromatherapy in palliative care requires further research. The present research has added to the knowledge base regarding acupuncture and aromatherapy in palliative care. Lessons learnt from the present study have been discussed, and future research in palliative care will be adapted to account for the difficulties experienced here (for example during the recruitment stage). Qualitative research on a larger scale will be required to enhance this knowledge, and further small scale studies will be useful.

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9. APPENDICES

9.1 Appendix A: Patient Information Sheet

Participant Information Sheet

The benefits of complementary therapies

You are invited to take part in a research study. Before you decide, please take the time to read the following information. It will help you to understand why the research is being done and what it would involve for you.
The purpose of this study is to find out what your feelings are about the benefits of complementary therapies. The researcher is doing this as part of a masters degree. You have been chosen because you are about to embark on a course of therapy at the hospice. There will be 8-12 participants in total.

Do I have to take part?

No. Your participation is entirely voluntary.

What will happen to me if I take part?

The research will involve meeting with you briefly prior to your chosen therapy. You will be asked some questions about how you have been feeling. You will then be asked to keep a daily diary of your symptoms After your course of therapy has finished I will contact you by telephone and arrange a convenient date and time to visit you at home, this is to conduct a short interview lasting approximately 45-60 mins. The researcher will not have access to your medical records as it is only your feelings that are being studied. Any other treatment you are having will continue as normal. The interview will be tape recorded to allow the researcher to listen to it several times. No one else will have access to the tape or anything that is written down about you.

Any information you give me will be confidential and you will be anonymous when the results are published.

No payment will be received for your participation.

What are the possible disadvantages of taking part?

During the interview we will be discussing how you have been feeling. It is possible this may be upsetting to you. If this is the case we will stop the interview.

What are the possible advantages of taking part?

You may see the benefits of the therapy more clearly by keeping a symptom diary or, on the other hand, you may realise the therapy is not helpful to you and choose not to start another course. You may benefit from having someone to talk things through with. The researcher is a trained district nurse with experience in palliative care.

What happens if I don't want to carry on with the study?

You may withdraw at any time, your therapy would not be affected in any way. If you do withdraw any information I have about you would be destroyed.

(second page overleaf)

What will happen to the results of the study?

Results will be made available to you once the study is completed. I will contact you to ask if you wish to receive a copy of the report. The results will also be presented to the hospice and may appear in nursing journals in order to help other professionals to understand how patients feel.

Who has reviewed the study?

All research in the NHS is looked at independently by a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by Wrightington, Wigan & Leigh Research Ethics Committee.

Further information and contact details

For further information or an informal chat please contact the researcher directly:

(contact details removed)

Or you may contact the matron at the hospice on.....

(names and phone numbers have been removed to maintain confidentiality)

9.2 Appendix B: Consent Form

Consent Form

Study title: The benefits of complementary therapies

Name of Researcher: Donna Regan

Participant Identification Number:

Please initial box

1. I confirm that I have read and understand the information sheet dated 2.5.07 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I Understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that data collected during the interview will be made public but that I will remain anonymous. ☐
4. I agree to my GP being informed of my participation in the study. ☐
5. I agree to take part in the above study. ☐

Name of Patient	Date	Signature
Name of Person taking consent	Date	Signature

When completed: 1 for patient, 1 for researcher, 1 (original) to be kept in medical notes.

REC Ref: 07/Q1410/19 Version 2, 2nd May 2007

9.3 Appendix C: Daily Diary

Daily Diary

Please record a few words about how you have been feeling. An example is given below.

DAY/DATE	
example	Lot of pain in leg today, took oramorph 4 times *or* felt good today
Wed 25th July	
Thur 26th	
Fri 27th	
Sat 28th	
Sun 29th	
Mon 30th	
Tue 31st	Therapy day
Wed 1st August	
Thur 2nd	
Fri 3rd	
Sat 4th	
Sun 5th	
Mon 6th	
Tue 7th	Therapy day
Wed 8th	
Thur 9th	
Fri 10th	
Sat 11th	
Sun 12th	
Mon 13th	
Tue 14th	Therapy day
Wed 15th	
Thur 16th	
Fri 17th	
Sat 18th	
Sun 19th	
Mon 20th	
Tue 21st	Therapy day
Wed 22nd	
Thur 23rd	
Fri 24th	

(second page overleaf)

Sat 25th	
Sun 26th	
Mon 27th	
Tue 28th	Therapy day
Wed 29th	
Thur 30th	
Fri 31st	
Sat 1st September	
Sun 2nd	
Mon 3rd	
Tue 4th	Therapy day
Wed 5th	
Thur 6th	
Fri 7th	
Sat 8th	
Sun 9th	
Mon 10th	
Tue 11th	Therapy day

9.4 Appendix D: EORTC Quality-of-Life Questionnaire

ENGLISH

EORTC QLQ-C30 (version 3)

We are interested in some things about you and your health. Please answer all of the questions yourself by circling the number that best applies to you. There are no "right" or "wrong" answers. The information that you provide will remain strictly confidential.

Please fill in your initials: _____

Your birthdate (Day, Month, Year): _____

Today's date (Day, Month, Year): 31 _____

	Not at All	A Little	Quite a Bit	Very Much
1. Do you have any trouble doing strenuous activities, like carrying a heavy shopping bag or a suitcase?	1	2	3	4
2. Do you have any trouble taking a long walk?	1	2	3	4
3. Do you have any trouble taking a short walk outside of the house?	1	2	3	4
4. Do you need to stay in bed or a chair during the day?	1	2	3	4
5. Do you need help with eating, dressing, washing yourself or using the toilet?	1	2	3	4

During the past week:	Not at All	A Little	Quite a Bit	Very Much
6. Were you limited in doing either your work or other daily activities?	1	2	3	4
7. Were you limited in pursuing your hobbies or other leisure time activities?	1	2	3	4
8. Were you short of breath?	1	2	3	4
9. Have you had pain?	1	2	3	4
10. Did you need to rest?	1	2	3	4
11. Have you had trouble sleeping?	1	2	3	4
12. Have you felt weak?	1	2	3	4
13. Have you lacked appetite?	1	2	3	4
14. Have you felt nauseated?	1	2	3	4
15. Have you vomited?	1	2	3	4
16. Have you been constipated?	1	2	3	4

Please go on to the next page

(second page overleaf)

ENGLISH

During the past week:	Not at All	A Little	Quite a Bit	Very Much
17. Have you had diarrhea?	1	2	3	4
18. Were you tired?	1	2	3	4
19. Did pain interfere with your daily activities?	1	2	3	4
20. Have you had difficulty in concentrating on things, like reading a newspaper or watching television?	1	2	3	4
21. Did you feel tense?	1	2	3	4
22. Did you worry?	1	2	3	4
23. Did you feel irritable?	1	2	3	4
24. Did you feel depressed?	1	2	3	4
25. Have you had difficulty remembering things?	1	2	3	4
26. Has your physical condition or medical treatment interfered with your family life?	1	2	3	4
27. Has your physical condition or medical treatment interfered with your social activities?	1	2	3	4
28. Has your physical condition or medical treatment caused you financial difficulties?	1	2	3	4

For the following questions please circle the number between 1 and 7 that best applies to you

29. How would you rate your overall health during the past week?

1	2	3	4	5	6	7
Very poor						Excellent

30. How would you rate your overall quality of life during the past week?

1	2	3	4	5	6	7
Very poor						Excellent

9.5 Appendix E: Interview Questions

Background information:

1) Can you tell me what complementary therapy you had?

2) Was this continuous for the whole course?

3) Did you have any other complementary therapies during this course?

4) Did you have any conventional treatment during this course?

General questions:

1) How did you feel physically before you started the acupuncture/aromatherapy?

2) How did you feel in yourself before you started the acupuncture/aromatherapy?

3) How did you feel about having the acupuncture/aromatherapy?

4) How did you feel during the therapy sessions? Please describe it to me.

5) How long did these effects/feelings last?

6) How did you feel the day after each therapy session?

7) How did you feel the day before each therapy session?

8) Why did you decide to try acupuncture/aromatherapy?

9) What did you like the most about the therapy sessions?